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FISCAL IMPACT STATEMENT

LS 7434
BILL NUMBER: SB 551

NOTE PREPARED: Feb 26, 2013
BILL AMENDED: Feb 25, 2013

SUBJECT: Federal Health Care Reform.

FIRST AUTHOR: Sen. Miller Patricia
FIRST SPONSOR: Rep. T. Brown

BILL STATUS: As Passed Senate

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: This bill provides for implementation of the federal Patient Protection and Affordable Care Act (ACA) with respect to a health insurance exchange (HIX) in Indiana. It specifies requirements for health plans issued through a HIX including application of Indiana insurance law.

The bill requires certification of navigators and registration of application organizations related to a HIX.

The bill provides for dissolution of the Indiana Comprehensive Health Insurance Association (ICHIA).

The bill extends the deadline for the Family and Social Services Administration (FSSA) to apply for a Medicaid State Plan Amendment for family planning services and supplies as allowed by the ACA.

The bill defines populations that may be subject to Medicaid resource requirements. The bill also specifies Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost sharing amounts. It also eliminates certain Medicaid eligibility resource requirements.

The bill provides for negotiations between the Office of Medicaid Policy and Planning (OMPP) and the United States Department of Health and Human Services (HHS) concerning a block grant system related to Medicaid.

The bill also requires the OMPP to apply to HHS to amend the state Medicaid plan to require Medicaid recipient cost sharing.

The bill requires the OMPP to present specified information to the Health Finance Commission (Commission)

before August 1, 2013. It also requires certain state agencies to report to the Commission concerning a HIX in Indiana.

Effective Date: Upon passage; July 1, 2013.

Summary of NET State Impact: *Summary:* Certain provisions in the bill are required to be done to comply with the implementation of the ACA. The resources necessary to accomplish these provisions are assumed to be included in the budget requests of the affected agencies or the Medicaid forecast for the biennium.

The dissolution of ICHIA would result in savings of approximately $10.6 M in FY 2014 and $48.85 M in FY 2015 if the current appropriation level is considered to be the baseline budget. The establishment of regulations concerning Navigators and assisters is intended to be self-funding. Other provisions depend on negotiations with the federal government and are indeterminate.

Medicaid Resource Standard Revision: The bill provides that, excluding the aged, blind, and disabled population, most Medicaid eligibility categories applicable to applicants between ages 19 to 65 will have no resource test applied to determine Medicaid eligibility as required under the ACA. The fiscal impact of this provision if any, should be a factor in the "woodwork effect" projections included in the September 18, 2012, "Milliman Medicaid Financial Impact Analysis" and should therefore be included in the December Medicaid forecast.

Elimination of the Section 209(b) Status/Conversion to 1634 Status: The bill specifies that the aged, blind, and disabled population will be subject to asset limitations established by the federal Supplemental Security Income program. The bill also specifies Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost-sharing amounts. These provisions are linked to the conversion of the state to 1634 disability determination status that is included as an assumption used to develop the December Medicaid forecast.

Authority to Negotiate a Block Grant including Medicaid Expansion and Cost Sharing: The fiscal impacts of these provisions depend on actions required to be taken by the FSSA and the response of the federal government. They are therefore indeterminate.

The bill provides enabling language to allow the Department of Insurance (DOI) and the Family and Social Services Administration (FSSA) to adopt rules, to contract with, and to share data with a health insurance exchange (HIX). These provisions are required as a result of the implementation the ACA.

The bill also requires the establishment of a course of study, an examination, and certification and registration procedures for persons or application organizations intending to act as navigators or application organizations with regard to the HIX required under the ACA. This provision is required to be supported by the fees assessed on applicants.

The extension of the deadline for the application of the Medicaid State Plan amendment for family planning services has no fiscal impact since the State Plan amendment has been approved and the eligibility and services were made available to recipients effective January 1, 2013.

The Health Finance Commission reporting requirements should be accomplished within the current levels of

resources available to FSSA, DOI, and the ISDH.

Explanation of State Expenditures: *Authority to Negotiate Medicaid Block Grant Including an Expansion:* The bill authorizes the FSSA to negotiate with the U.S. Department of Health and Human Services to establish a Medicaid block grant system for providing Medicaid services to recipients, including those individuals described as the expansion population in the ACA. The bill would authorize any State Plan amendments or Medicaid waivers necessary to establish a program funded by a federal block grant. The bill specifies concerns and issues that must be included in any waiver or State Plan amendment that might be negotiated. The bill specifies that the FSSA may not implement a waiver or State Plan amendment until a sustainable financing plan has been developed and reviewed by the State Budget Committee. The fiscal impact of this provision is indeterminate. The authority granted is broad and applies to the entire Medicaid program including a possible expansion population. Any fiscal impact would depend on the outcome of the authorized negotiations.

Medicaid Cost-Sharing State Plan Amendment: The bill requires the FSSA to amend the State Plan to require Medicaid recipients to participate in cost sharing as allowable under federal law. Certain Medicaid recipients may already to be subject to cost sharing since a limited amount of cost sharing is allowable under federal law. The ACA allows states to design alternate benefit packages within specified parameters for defined populations. Proposed federal rules have been drafted that allow for higher cost sharing for individuals with incomes above 100% of FPL. However, without a specific proposal, the fiscal impact of this provision is indeterminate.

Revision of the Medicaid Resource Standard: In accordance with provisions of the ACA, the bill eliminates provisions allowing resource standards for pregnant women, children, and other specified populations. The bill specifies that resource standards may be applied to recipients and applicants that are aged, blind, or disabled, SSI-eligible, a person meeting level-of-care requirements and applying for long-term care services, or an individual applying for Medicare cost-sharing assistance. Most other eligibility categories between ages 19 and 65 will have no resource test applied. This provision of the ACA is intended to streamline the Medicaid application and eligibility determination process and is based on the assumption that the majority of low-income persons who earn less than the income eligibility standards do not have assets that would enable them to pay for health care. The fiscal impact of this provision if any, should be included in the September 18, 2012, "Milliman Medicaid Financial Impact Analysis" as part of the "woodwork effect" and should therefore also be included in the December Medicaid forecast.

Elimination of the Section 209(b) Status/Conversion to 1634 Status: The bill specifies that the aged, blind, and disabled population will be subject to asset limitations established by the federal Supplemental Security Income program. This provision would allow for the elimination of the separate disability determination process and the associated expenses as well as the Spend down Program.

Medicare Savings Program: The bill also specifies Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost-sharing amounts. These provisions are linked to the conversion of the state to 1634 disability determination status that is included as an assumption used to develop the December Medicaid forecast.

Oversight of Insurance Offered on the HIX: The bill specifies the Department of Insurance would provide oversight of insurance products provided through the HIX and that all requirements of the DOI apply to health plans offered on the exchange. The ACA specifies that all insurance offered on the HIX must meet state

insurance requirements as well as federal provisions. The bill also allows the DOI to enter into contracts with a HIX for the performance of necessary functions and to share information necessary to implement the HIX. The workload of the DOI will increase with the implementation of the federally facilitated exchange as a requirement of the ACA.

Registration of Application Organizations and Certification of Navigators: The bill also requires that individuals or application organizations intending to act as navigators in Indiana under the provisions of the ACA must meet state certification and registration requirements for HIX navigators and application organizations. (Federal rules implementing the HIX specify that in order to receive a Navigator grant, individuals or entities must meet any licensing, certification, or other standard prescribed by the state or the HIX, if applicable.) The DOI, in consultation with FSSA, is required to develop a curriculum for a required course of study and an examination that will be required for the certification of navigators. The bill also requires development of continuing education requirements for ongoing certification and for a process for an insurance producer or consultant to qualify to be designated as a navigator. The development of the certification and registration program will impact the workload of the DOI; however, the DOI is required to collect fees sufficient to cover the expense of the implementation of the certification and registration program. The DOI will need to promulgate rules to establish the requirements of the navigator certifications and the application organization registration requirements. Rule-making is considered to be a core activity of agencies and should be able to be accomplished within the current level of resources available.

Dissolution of ICHIA: As a result of the ACA and its elimination of preexisting conditions exclusions, limitation of annual and lifetime caps, and the inability to reject applicants due to health conditions, the ICHIA program is no longer necessary. There will no longer be a need to operate the high-risk ICHIA program after coverage for insurance sold on the HIX becomes effective January 1, 2014. The bill requires the corporation to submit a plan of dissolution and specifies items that must be included in the plan. The DOI is responsible for approval of the dissolution plan. The termination of the ICHIA program is not a requirement of the ACA - it is no longer necessary because of the ACA.

The dissolution of ICHIA will require ICHIA participants to transition to qualified insurance products sold on the HIX. (These products are projected to cost less than the coverage offered under ICHIA.) The ICHIA General Fund appropriation for the current biennium is $97.7 M The corporation has prepared a plan for termination and transition of participants, which is included in the FY 2014 - FY2015 budget request. The ICHIA has requested $38.25 M for the upcoming biennial budget to pay the remaining projected incurred claims tail, and to discontinue other activities managed by the program. If the current appropriation level is considered to be the baseline budget, the repeal would result in savings of approximately $10.6 M in FY 2014 and $48.85 M in FY 2015. The bill also provides that any funds remaining in the ICHIA on the date of the final dissolution must be transferred to the General Fund.

Termination of ICHIA Coverage Effect on Healthy Indiana Plan (HIP): The bill would allow former ICHIA participants who no longer have coverage under ICHIA, and who otherwise meet the income eligibility and other requirements of the HIP Medicaid waiver to be eligible for the HIP benefits without going without coverage for the currently required 6-month period of time. The provision would require a waiver amendment to allow the waiving of the waiting period to be submitted to CMS and approved in order to receive the federal matching funds for this population, which is likely to be small. Further, the HIP program waiver would have to be extended or renewed in order to be of use to former ICHIA participants since it expires December 31, 2013.

Reporting Requirements: The bill requires the OMPP to present to the General Assembly and the Health Finance Commission a plan concerning a requirement for risk-based managed care for individuals enrolled in an aged, blind, or disabled eligibility category of the Medicaid program and how health care should be provided for current Healthy Indiana Plan members and individuals that are dually eligible for Medicaid and Medicare. The OMPP is also to provide information regarding the number of participants in the two programs who would be eligible for a tax credit under the provisions of the ACA.

Additional Information: Premium Assistance Tax Credits : Dually eligible individuals would not be eligible for premium assistance tax credits nor would any HIP participant below 100% FPL. At the end of September 2012, there were 41,064 enrolled participants in the HIP program, 70% of whom, or 28,736, had income levels at or below 100% of the FPL and therefore would not be eligible for premium assistance. (The premium assistance amount is not available for any coverage month that an individual is eligible for minimum essential coverage outside the individual issue market. Minimum essential coverage is health insurance coverage under Medicare, Medicaid, the Children's Health Insurance Program (CHIP), military service and Peace Corps-related coverage, an employer-sponsored plan, or a grandfathered plan.) Additionally, the tax credits can only be obtained by qualifying individuals who file federal tax returns.

2013 Federal Poverty Guidelines						
# in Family/ Household	**100% FPL**	**138% FPL**	**150% FPL**	**200% FPL**	**300% FPL**	**400% FPL**
1	11,490	15,856	17,235	22,980	34,470	45,960
2	15,510	21,404	23,265	31,020	46,530	62,040
3	19,530	26,951	29,295	39,060	58,590	78,120
4	23,550	32,499	35,325	47,100	70650	94,200
5	27,550	38,019	41,325	55,100	82,650	110,200
6	31,590	43,594	47,385	63,180	94,770	126,360

Explanation of State Revenues: The DOI is required to collect from navigator and assister applicants for certification, registration, and renewal fees sufficient to cover the costs of implementing a prescribed course of study, an examination, and continuing education requirements. [See *Explanation of State Expenditures* above.]

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: DOI; ICHIA; FSSA.

Local Agencies Affected:

Information Sources: Douglas Stratton, ICHIA Executive Director; Logan Harrison, DOI; Seema Verma, Indiana State Health Care Reform Lead, FSSA; "General Guidance on Federally-Facilitated Exchanges", Center for Consumer Information and Insurance Oversight, CMS; Federal Register/Vol. 77, No. 59, March

27, 2012, Section 155.210 and Section 155.220.

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